FEDERAL COURT OF AUSTRALIA

Lowe v Certain Underwriters at Lloyd's of London Subscribing to Policy Number ATCSI00100 [2024] FCA 858

File number(s):	NSD 1311 of 2023
Judgment of:	**JACKMAN J**
Date of judgment:	2 August 2024
Catchwords:	**INSURANCE** – professional sports person personal accident and sickness policy – where applicant retired from professional rugby league following a crusher tackle – meaning of "hemiplegia" **INSURANCE** – whether injury was caused by an accident "solely and independently of any other cause" – where injury was made worse as a result of a similar incident four years earlier
Cases cited:	*CGU Insurance Ltd v Porthouse* [2008] HCA 30; (2008) 235 CLR 103 *Fidelity and Casualty Company of New York v Mitchell* [1917] AC 592 *Jason v Batten (1930) Limited* [1969] 1 Lloyd's Rep 281 *L Schuler AG v Wickman Machine Tool Sales Ltd* [1974] AC 235 *Lasermax Engineering Pty Ltd v QBE Insurance (Australia) Ltd* [2004] NSWSC 483 *Lasermax Engineering Pty Ltd v QBE Insurance (Australia) Ltd* [2005] NSWCA 66 *Lipertis v Australian Casualty Company Pty Ltd* [1983] 2 VR 280 *Mount Bruce Mining Pty Ltd v Wright Prospecting Pty Ltd* [2015] HCA 37; (2015) 256 CLR 104 *Preston v AIA Australia Ltd* [2014] NSWCA 165 *Quasar Resources Pty Ltd v APG Aus No 3 Pty Ltd* [2023] WASCA 171 *Rheem Australia Pty Ltd v Mitsui Sumitomo Insurance Company Ltd* [2023] FCA 1570 *Silverstein v Metropolitan Life Ins Co* (1930) 171 NE 914 (Court of Appeals of New York) Heydon, JD, *Heydon on Contract* (2019) [8.390

Division:	General Division
Registry:	New South Wales
National Practice Area:	Commercial and Corporations
Sub-area:	Commercial Contracts, Banking, Finance and Insurance
Number of paragraphs:	104
Date of hearing:	15–16 July 2024
Counsel for the Applicant:	Mr C O'Neill and Mr N Lennings
Solicitor for the Applicant:	Macpherson Kelley
Counsel for the Respondents:	Mr D Williams SC and Mr D Emmerig
Solicitor for the Respondents:	Gilchrist Connell

ORDERS

NSD 1311 of 2023

BETWEEN:	**ETHAN JOHN LOWE** Applicant
AND:	**CERTAIN UNDERWRITERS AT LLOYD'S OF LONDON SUBSCRIBING TO POLICY NUMBER ATCSI00100** Respondents

ORDER MADE BY:	**JACKMAN J**
DATE OF ORDER:	**2 AUGUST 2024**

THE COURT ORDERS THAT:

1. The originating application be dismissed.
2. The respondents file and serve written submissions and any affidavits on costs by 9 August 2024.
3. The applicant file and serve written submissions and any affidavits on costs by 16 August 2024.
4. The respondents file and serve written submissions and any affidavits in reply on costs by 23 August 2024.

Note: Entry of orders is dealt with in Rule 39.32 of the *Federal Court Rules 2011*.

REASONS FOR JUDGMENT

JACKMAN J:

Introduction

1 By Originating Application dated 7 November 2023, the applicant, Mr Ethan Lowe, seeks a declaration and order for indemnity against the respondents (the **Insurers**) that a Professional Sports Person Personal Accident and Sickness Insurance Policy for the period 11 December 2019 to 11 December 2020 subscribed to by the Insurers and bearing policy number ATCSI00100 (**the Policy**) indemnifies him for a claim he made on 10 December 2021 (**the Claim**).

2 Mr Lowe was formerly a professional rugby league football player in the National Rugby League (**NRL**). He played with the North Queensland Cowboys from 2013 to 2018 (including as a member of the Premiership winning team in 2015), and for the South Sydney Rabbitohs in 2019 and 2020. In 2019, he played for Queensland in the third game of the annual State of Origin series. On 18 July 2020, he suffered a significant injury while being tackled playing for the South Sydney Rabbitohs, in a type of tackle known as a "crusher", involving forced flexion followed by hyperextension of the cervical spine due to pressure on the head, with immediate left upper and lower limb numbness indicative of neural compromise (the **2020 Injury**). Mr Lowe then retired from professional rugby league.

3 By its Concise Statement in Response dated 22 December 2023, the Insurers raise two issues for determination:

(a) whether Mr Lowe's "Bodily Injury" is "Permanent hemiplegia" as defined by the Policy; and

(b) whether Mr Lowe's injury satisfies the definition of Bodily Injury as being "caused by an Accident and solely and independently of any other cause".

4 The word Permanent is defined by the Policy. Hemiplegia is not defined in the Policy. The first issue therefore turns upon: (a) the construction of the word "hemiplegia" as used in the Policy, and (b) whether Mr Lowe suffers such a condition.

5 The second issue turns on an analysis of causation. There is no contest that the 2020 Injury was "caused by an Accident". The question is whether it was caused "solely and independently of

any other cause". This turns on the causal significance (if any) of an earlier injury which Mr Lowe suffered on 10 September 2016.

The Policy

6 At the time of the 2020 Injury, the NRL was subscribed to the Policy which was issued by the Insurers and effected on their behalf by ATC Insurance Solutions Pty Ltd. The Policy applied from 11 December 2019 to 11 December 2020. The Policy included Professional Accident & Illness Insurance Professional Sports Policy Wording v10.3 dated 15 January 2019 (the **Policy Wording**). Under the Policy, an "insured person" includes the "Top 30 remunerated players per NRL team". It is not disputed that Mr Lowe was an "insured person".

7 Clause 1 of the Policy Wording states:

> In consideration of the payment of the required Premium(s) by the Premium Due Date and subject to all the conditions, definitions and exclusions of this insurance, We agree with You, to the extent and in the manner set out in this insurance, to pay the benefits set out in this Policy and Schedule to You or, in the event of Your Accidental Death, to Your nominated Beneficiary.

8 The Policy Schedule provides for "Additional Benefits" as follows:

Insured Event	Benefit payable
Bodily Injury resulting in:	
1. Permanent paraplegia, Permanent quadriplegia, Permanent hemiplegia or Permanent triplegia	$1,000,000
2. Permanent total loss of sight of both eyes	$1,000,000
3. Permanent total loss of sight in one eye	$500,000
4. Permanent total loss of use of one limb	$1,000,000

9 The word "Permanent" is defined in the Policy Schedule as meaning:

> disablement from a Bodily Injury that entirely prevents you from engaging in Your usual Occupation as stated in the Schedule [namely, professional rugby league player] and which either lasts for at least 12 months and then be without prospect of improvement, or is and when We determine that You are Permanently Totally Disabled, whichever happens first.

The Insurers accept that the definition of "Permanent" is satisfied in the present case.

10 A "Bodily Injury" is defined in the Policy to mean "identifiable physical injury which is caused by an Accident and solely and independently of any other cause (except Illness directly resulting from or medical or surgical treatment rendered necessary by such Bodily Injury) results in Your death or disablement within twelve months from the date of the Accident."

11 An "Accident" means "a sudden, unexpected, unusual, violent and specific event which occurs at an identifiable time and place during the Period of Insurance." There is no dispute that Mr Lowe sustained an "Accident" at the time of the 2020 Injury.

Salient Facts

The 2016 Injury

12 On 10 September 2016, Mr Lowe suffered an injury during the early stages of a rugby league game when he was tackled and downward pressure on the back of his head briefly compressed his chin into his chest. Mr Lowe described an immediate tingling sensation throughout his body for a matter of seconds with a tingling numbness remaining in both hands (the **2016 Injury**). Mr Lowe played throughout the rest of the game, which will not come as a surprise to those familiar with the nature and challenges (not to mention the satisfactions) of contact team sports.

13 On 12 September 2016, Mr Lowe underwent an MRI scan of his cervical spine. In a letter of the same date from Dr Geoffrey Haussman of Queensland X-Ray to Dr Christopher Ball (Cowboys Club Doctor), Dr Haussman identified that "[a]t the C5/6 level, there is a large left paracentral disc protrusion" and that the protrusion was causing "significant canal stenosis towards the left side of the canal – with complete effacement of CSF anterior and posterior to the cord and significant deformity of the cord" (CB116). The report also noted that "the pre operative study does demonstrate minor cord oedema at the C5/6 level however this appears to have largely resolved".

14 On 13 September 2016, Dr Eric Guazzo (neurosurgeon) met with Mr Lowe. Dr Guazzo described the MRI findings as depicting "a very large extruded central and left-sided C5/6 disc protrusion". Dr Guazzo and Mr Lowe discussed surgical alternatives to address the issue including:

(a) an anterior cervical discectomy and interbody fusion,

(b) a disc replacement, and

(c) a microsurgical approach to remove the extruded fragment.

Of these three, Mr Lowe chose the least invasive microsurgical approach. The continuing option of discectomy and fusion was kept under review. Mr Lowe ultimately had such surgery after the injury which he sustained in July 2020.

15 On 27 September 2016, Mr Lowe underwent spinal surgery, being a left C5-6 foraminotomy and microdiscectomy for central and lateral disc protrusion causing cord compression (the **2016 Surgery**) (CB120). The procedure was conducted by Dr Guazzo.

16 The Operation Report dated 27 September 2016 prepared by Dr Guazzo for the surgery refers to "disc material" and states that "[c]arefully the free fragments of disc were removed". The nerve root after decompression resumed its normal position (CB120). Similarly, in a letter from Dr Guazzo to Dr Ball dated 29 September 2016 in relation to the operation, Dr Guazzo states that "[t]here were some free fragments superior to the posterior longitudinal ligament and these were removed. Inferior to the ligament, further disc material was removed to thoroughly decompress the theca." Mr Lowe's postoperative recovery was described as uneventful and he was discharged from hospital that day (CB122).

17 By 3 November 2016, Dr Guazzo reported in a letter to Dr Ball that Mr Lowe's progress post-surgery was "very satisfactory. He reports no residual symptoms. His neck is well healed." Dr Guazzo cleared Mr Lowe to begin some "light non-contact exercise" (CB123).

18 On 9 January 2017, Mr Lowe underwent an MRI scan of his cervical spine. Notes of the scan recorded "persistent left posterior paracentral disc protrusion however of reduced size since the pre operative scan". There remained "some disc encroachment on the left C6 foramen." The cervical cord at the C5/6 level was reported to be "indented anteriorly on the left. There is a congenitally narrow spinal canal and at the C5/6 level there is persistent effacement of the CSF space both anterior and posterior to the cord" (CB437).

19 On 12 January 2017, Dr Guazzo cleared Mr Lowe to return to contact sport. In a letter to Dr Ball, Dr Guazzo stated (CB124):

> His repeat MRI shows a residual disc protrusion at C5–6 and he has a continually narrow canal. The disc protrusion is significantly smaller and the degree of minor cord oedema that was present in the preoperative study has resolved.
>
> I have explained to Ethan and his partner that I cannot quantify his risk of further injury, however current evidence suggests that his risk is no greater than it was before because he is now asymptomatic. I recommended that he can return to contact sport and that he should have a repeat MRI in three months and I will see him at that time. If he develops any concerning symptoms I will be pleased to review him sooner.

The 2017 Injury

20 On 31 March 2017, Mr Lowe suffered another injury during play after receiving a "blow to the head" (CB127) making a defensive tackle (the **2017 Injury**). A letter from Dr Ball to Dr

Guazzo dated 3 April 2017 reported Mr Lowe having "an episode of hyperflexion" and that he "had a few seconds of medial thigh symptoms. He had a minute or so of right hand symptoms and several minutes perhaps longer of left hand ulna nerve symptoms" (CB433).

21 On 1 April 2017, Mr Lowe underwent an MRI scan of his cervical spine (CB125). The notes of the scan recorded posterior paracentral disc protrusion virtually identical to the post operation MRI from January 2017. However, an amended report dated 3 April 2017 records that "there is very subtle hyperintense signal in the left lateral aspect of the cord which could reflect mild cord oedema or myelomalacia. Unfortunately the axial images are quite motion degraded and are non-contributory. Nonetheless, given the history of new symptoms, this does raise the possibility of recent injury to the cord although the degree of disc bulge is, as previously mentioned, virtually identical compared to the scan from January 2017" (CB126).

22 On 6 April 2017, Dr Guazzo wrote to Dr Ball, referring to Mr Lowe having played trial games and five competition games in 2017, identifying some generalised mild hyperflexia on physical examination and stating (CB127):

> You will know that I did discuss his circumstance with one of my colleagues in Sydney. We both agree that the traditional approach would be that he should probably go forward to a fusion or disc replacement. It is impossible to quantify the risk if he wants to continue playing without further treatment. There must be some increased risk in view of the disc protrusion, but then we do not know how many people playing the game already have a disc protrusion of a similar size and exposed to the same risk. Some information from the North America suggested it is more common than we consider.
>
> What we have decided today, and Ethan understands all the information we have discussed, he will play this weekend. If he develops any symptoms at all, he will discontinue playing and proceed to surgery. Otherwise, I will see him again in six weeks with a repeat MRI. Lastly, we discussed at the end of the season if he has continuing substantial disc protrusion he may elect to consider a surgery during the off season.

Mr Lowe resumed playing rugby league on 8 April 2017.

23 On 4 May 2017, Mr Lowe underwent an MRI scan of his cervical spine (CB132). The notes of the scan recorded that there was "[m]ultilevel disc degeneration within the cervical spine" and that there remained "a prominent disc bulge at C5/6 in a left posterior paracentral location which is indenting the cervical spinal cord at this level on the left". It was possible that "there was a subtle area of increased T2 signal within the left lateral aspect of the cord which may indicate mild oedema or myelomalacia" (CB132).

24 On 5 May 2017, Dr Guazzo prepared a letter to Dr Ball referring to a recent MRI and noting "if anything, some improvement" in the degree of disc protrusion. He indicated that "[t]he small area of signal change in the cord was evident on the previous MRIs and relates to the initial disc protrusion." Dr Guazzo stated that it was reasonable for Mr Lowe to continue to play, but that he would continue with "the close observation policy" (CB131).

25 On 8 June 2017, Mr Lowe underwent an MRI scan of his cervical spine (CB135). The notes from the scan record that "the disc protrusion effaces the CSF space anterior to the cord with some distortion of the left side of the cervical cord. The disc material also extends into the left C6 foramen with possible compromise of the left C6 nerve root. The increased signal intensity within the left side of the cord at this level extending over 14mm longitudinal length is similar to previous imaging".

26 On 12 June 2017, Dr Guazzo wrote a letter to Dr Ball noting that a recent MRI looked "quite satisfactory" compared to a January 2017 scan and stating (CB134):

> We have decided that he will not have any further routine MRIs until the end of the season when we will make decisions as to whether to he will proceed to discectomy and fusion.
>
> My thoughts are similar to that of Ethan's and if he is completely asymptomatic and his MRI is reasonable then he probably will not have any further surgery at that time.

27 On 31 August 2017, Mr Lowe underwent an MRI scan of his cervical spine. The report of Dr Kurundeniya Prematunga dated 31 August 2017 noted that "There is anterior indentation to the thecal sac and the spinal cord. There is oedema of the cord extending from the lower border of C4 to upper border of C6. The oedema is best demonstrated on sagittal images…. There appears to be minimal progression of the cord oedema craniocaudally as demonstrated on sagittal images" (CB137).

28 On 5 October 2017, Dr Guazzo wrote a further letter to Dr Ball in relation to a consultation held with Mr Lowe that day. In the letter, Dr Guazzo referred to Mr Lowe's performance on the field recently as showing that his function with regard to strength and coordination was unimpaired, and wrote (CB136):

> Today, as we had done on a number of occasions, we discussed the pros and cons of further surgery. There is no doubt that in view of his disc protrusion, he must be at slightly increased risk of cord injury if he sustains a serious injury to his neck. We know from North American studies many people who play similar contact sports have disc protrusions and go about playing without consequence.
>
> The alternative is for Ethan to go ahead and have an anterior cervical discectomy and

> interbody fusion. While this is likely to be successful, there is no guarantee that this will result in he being able to return to playing or furthermore alter the risk of cord injury or neck problems consequent to further injury.
>
> It is a difficult decision to make and there are no firm guidelines.

29 On 4 December 2017, Dr Guazzo indicated in a letter to Dr Ball that Mr Lowe was "completely asymptomatic and has returned to pre-season training" and that Dr Guazzo and Mr Lowe "have decided that he will continue as he is without any surgical intervention. I will see him again if there are any concerns" (CB139).

The 2020 Injury

30 On 18 July 2020 in the NRL Round 10 game against the Newcastle Knights, Mr Lowe was tackled with his neck forced into a position of forceful flexion before his neck was released and flicked back into a position of extension (the **2020 Injury**) (CB142). Mr Lowe described this as a "crusher" style motion. Mr Lowe immediately felt a strong tingling and shooting pain through his left arm and hand, and felt unsteady on his left leg as though his left knee was about to give way. Mr Lowe finished playing that game, but complained post-game and the following morning of constant paraesthesia in fingers in his left hand (CB142).

31 On 19 July 2020, Mr Lowe underwent an MRI scan of his cervical spine, which recorded that he had suffered at the C5-6 vertebrae (CB140):

> a large right paracentral to left foraminal disc protrusion which causes significant mass effect on the left hemicord, severe left lateral recess stenosis, left neural exit foraminal stenosis and moderate to severe central canal stenosis. Probable impingement of the exiting left C6 nerve root within the neural exit foramen. Hyperintensity within the left hemi cord extending from the level of the mid C5 vertebral body to the middle C6 vertebral body (1.8 cm in length) appears to be a combination of oedema and myelomalacia. Mild right posterolateral/foraminal disc bulge causes mild right neural exit foraminal stenosis. No significant facet joint arthropathy.

32 On the same day, Mr Lowe visited the Rabbitohs Club Doctor, Dr Andrew McDonald, who referred him to the neurosurgeon Dr Richard Parkinson (CB142). In the letter of referral, Dr McDonald discussed the results of the MRI scan and reported that "Ethan presents with left hand paraesthesia and weakness." He reported that a previous MRI had shown "a large central / left paracentral disc protrusion causing significant canal stenosis with complete effacement of CSF anterior and posterior to the cord and significant deformity to the cord" (CB142).

33 On 21 July 2020, Mr Lowe underwent surgery for a C5/C6 anterior cervical discectomy and fusion at Prince of Wales Private Hospital performed by Dr Parkinson (the **2020 Surgery**). In the Operation Report, Dr Parkinson's review of the 19 July 2020 MRI identified "a large

intracanalicular acutely herniated disc fragment at C5/6 causing severe compression of the right hemicord with a small haematomyelia, moderate cord oedema noted. There is significant effacement of the spinal canal and left hemicord. There is some loss in normal cervical lordosis. There are postoperative changes consistent with the previous foraminotomy noted. There is moderate facet-joint osteoarthropathy noted as well." (CB145)

34 Dr Parkinson's Operative Findings were (CB144):

> Large sequestration causing severe compression of left hemicord. Floating bone fragment due to previous foraminotomy also causing some foraminal compression. Significantly deflected dura. Operative video taken.

In relation to Mr Lowe's strength, Dr Parkinson noted (CB144):

> Clinically he was weak in the left arm in thumb abduction 4-+/5, brachioradialis 4+/5, triceps 4+/5, infraspinatus 4+/5 wrist and finger extension 4+/5, finger abduction 4+/5. There was a light-touch sensory loss over the first dorsal web space, index finger and thumb and over the middle finger with extension to the extensor forearm. Reflexes were not tested. Right upper limb power was normal.

Dr Parkinson also noted that Mr Lowe "is remarkably neurologically well considering the degree of compression" (CB145).

35 Following the 2016 Injury, Dr Guazzo had proposed three potential surgical options for Mr Lowe (as indicated above, an anterior cervical discectomy and interbody fusion, a disc replacement, and a microsurgical approach to remove the extruded disc fragment). Mr Lowe elected to have the third and least invasive of these options in September 2016. After the 2017 Injury, letters from Dr Guazzo on 6 April 2017, 12 June 2017 and 5 October 2017 record discussions with Mr Lowe considering potential surgery for a cervical discectomy and interbody fusion (CB127, 134 and 136). Following the 2020 Injury, Mr Lowe had a cervical discectomy and interbody fusion.

36 Following the surgery, Mr Lowe's symptoms did not improve, and Mr Lowe found himself being easily fatigued and suffering from decreased fine motor skills. As a result of Mr Lowe's symptoms, and in consultation with Dr McDonald (Rabbitohs Club Doctor), he made the preliminary decision to retire from professional rugby league in October 2020.

37 On 22 October 2020, Dr McDonald prepared a report for Mr Lowe's end-of-season exit medical (Exhibit E). This report included the observations that "on assessing the upper limbs there was weakness of left shoulder abduction, external rotation and on supraspinatus testing

(power 4-4.5/5), weakness of left triceps (4/5) and decreased power on pincer grip between the left thumb and fingers" (Exhibit E).

38 On 2 November 2020, Mr Lowe had a consultation with the orthopaedic surgeon Dr Ian Farey for a second opinion on his ability to return to play. At the meeting, Dr Farey was not able to review imaging but was shown an image of Mr Lowe's MRI on Mr Lowe's phone. Dr Farey's letter to Dr McDonald of the same date states (CB345, 386):

> Ethan has had a spinal cord injury as a result of a tackle and associated C5/6 disc protrusion. He has evidence of myelomalacia and has had a Brown-Sequard spinal cord injury.

Dr Farey's letter also included the following in relation to Mr Lowe's muscle function:

> Neurological examination revealed strong Grade IV power in the left triceps and left quadriceps muscles on the left side and hyperreflexia in the left lower limb with the plantar responses being flexor.

Dr Farey also noted from reviewing a photo of Mr Lowe's MRI scan "the presence of a large central and left sided disc protrusion at the C5/6 level with marked cord compression and myelomalacia".

39 There are two versions of this letter in evidence. The above extracts are taken from the version of this letter apparently faxed to Princess Alexandra Hospital on 1 March 2022 (CB386), being the same as the version provided to the Insurers when the claim was made on 9 December 2021 (CB342–5). The version exhibited to Mr Lowe's affidavit has the word "Hemiplegia" inserted in the last sentence of the first quotation above, such that it reads "a Brown-Sequard Hemiplegia spinal cord injury" (CB147). The evidence does not enable me to make any finding as to why there was more than one version of the letter. I note, however, that in each of the versions of the document, the letter concludes with an electronic signature and the disclaimer "letter dictated but not checked by Dr Farey".

40 On 2 November 2021, Mr Lowe underwent an MRI scan of his cervical spine. The report of Dr Gaurav Khera dated 3 November 2021 notes "[r]educed volume of left hemicord with bright signal area suggesting chronic myelomalacia at C5/6 level. This is likely sequala to old injury." (CB390).

41 On 25 November 2021, Dr Parkinson sent a letter to Dr McDonald in relation to Mr Lowe noting that "[h]e is still experiencing some left upper limb symptoms including some dysaesthesia over the extensor forearm. Repeat MRI imaging shows a stable and solid surgical

result with no evidence of residual cord or nerve compression, and residual myelomalacia consistent with a previous cord injury for which the surgery was required" (Exhibit D).

42 On around 10 December 2021, Mr Lowe made a claim under the Policy for $1,000,000 on the basis that his Bodily Injury was "permanent hemiplegia".

43 On 7 February 2022, Mr Lowe underwent a CT scan on his cervical spine. The findings in the report stated that "anterior cervical fusion from C5 to C6 with intervertebral body fusion device shows a stable appearance with no metal ware complication" (CB391).

44 On 4 March 2022, Dr Parkinson wrote to Dr McDonald that Mr Lowe "still has some brachioradialis, thumb abduction, and triceps weakness in his left hand with some dysaesthesais over the left thumb and index finger. Overall, however he is doing well and repeat CT scanning shows a satisfactory fusion". (Exhibit D)

45 On 27 April 2022, Mr Lowe had a consultation with Dr Parkinson by phone. Doctor Parkinson's letter of the same date to Dr Michael Wheeler in relation to the consultation stated (CB149):

> It was my pleasure to review Ethan again today via phone consultation. I confirm he has suffered a spinal cord injury and hemiplegia which has led to his retirement from the game and need for spinal surgery. If there are any other questions please let me know.

The Dr Panagoda consultation

46 On 19 May 2022, Dr Michael Wheeler referred Mr Lowe to the Princess Alexandra Hospital Spinal Injuries Unit (CB381–5). In Dr Wheeler's Spinal Injuries Unit Referral Form, Mr Lowe's diagnosis was described as "Brown-Sequard Syndrome" (CB381). In the attached letter, Dr Wheeler stated that Mr Lowe "[h]as ongoing L sided Brown-Sequad [sic] syndrome" (CB384).

47 On 1 August 2022, Mr Lowe had a consultation with Dr Claire Panagoda, Staff Specialist, Spinal Injuries Unit at the Queensland Spinal Cord Injuries Service at Princess Alexandra Hospital, to assess his symptoms and general condition. It appears that two key documents arose from that consultation;

(a) first, a document titled "Progress Notes" (which is also labelled "Final Report") which on its face was signed by Dr Panagoda at 4:27 pm on the same day (**Panagoda Progress**

Notes) (CB154). This document appears to be rough notes recording the contents of the consultation;

(b) second, correspondence from Dr Panagoda to Dr Wheeler dated 11 August 2022 (**Panagoda Correspondence**) which discussed the consultation in greater detail and clarified important aspects of the Panagoda Progress Notes (CB393). On the face of the document, the Panagoda Correspondence appears to have been prepared on 8 August 2022 and signed by Dr Panagoda at 11:46am on 11 August 2022.

48 The Insurers submit, and I accept, that the Panagoda Correspondence is a formalisation and clarification of the Panagoda Progress Notes. This is supported by the facts that:

(a) Mr Lowe's evidence only mentions one visit with Dr Panagoda;

(b) in the Panagoda Correspondence, Dr Panagoda states that "I had the pleasure of meeting Ethan for his first appointment in the Spinal Injuries Unit, Outpatient Clinic";

(c) the Panagoda Progress Notes state under "Recommendations" that there is "No need to return to SIU OPD"; and

(d) the headings and content of the two documents align and relate to the same content.

49 The two documents record the following in relation to the consultation of 1 August 2022:

Panagoda Progress Notes	**Panagoda Correspondence**
"Primary diagnosis C5 AIS D tetraplegia due to rugby league injury 2020 in NSW - C5/6 disc prolapse due to hyperflexion injury during tackle No PMHx Left hand dominant" (CB154).	"Primary diagnosis: C5 AIS D spinal cord injury (atypical Brown-Sequard Syndrome) due to a traumatic disc prolapse sustained whilst playing professional rugby league in 2020. C5/6 disc prolapse requiring ACDF 2020. This is on the background of a previous disc prolapse in 2016, managed surgically (posterior approach ? decompressive laminectomy) Left hand dominant. No other past medical history" (CB393).

Panagoda Progress Notes	Panagoda Correspondence
"Current function/equipment: Gym twice weekly - upper and lower body resistance - runs once weekly, ok on flat surfaces, balance impaired on uneven ground Falls but infrequent" (CB155).	**"Current Function/Equipment** Ethan continues to attend the gym twice weekly, performing upper and lower body resistance work. He is able to run about once a week but needs to remain on flat surfaces as his balance/proprioception is impaired on uneven ground. He falls infrequently" (CB394).
"Impression: Incomplete cervical SCI - presents as (L) hemiplegia - stable neuro impairment, high level of function however significant decline from premorbid elite athlete level. Associated challenges with adjustment - no bladder/bowel/sexual function involvement" (CB156).	**"Impression** Ethan has an incomplete cervical spinal cord injury. This presents as asymmetrical neurological impairments with the left being affected in hemiplegic-like pattern. The changes are stable and Ethan has a high level of function, however this presents a significant decline from his premorbid elite athlete level. He is experiencing associated challenges with adjustment. It is fortunate that there are no bladder, bowel or sexual function issues" (CB395).

50 The Insurers draw attention to the following matters arising from these clarifications:

(a) the Panagoda Progress Notes record Mr Lowe's primary diagnosis as "C5 AIS D tetraplegia", while the Panagoda Correspondence refers to "C5 AIS D spinal cord injury (atypical Brown-Sequard Syndrome)". It is common ground that the description of "tetraplegia" is mistaken;

(b) both documents record Mr Lowe maintaining an active physical life, going to the gym twice a week and running on flat ground;

(c) while the Panagoda Progress Notes state that Mr Lowe "presents as (L) hemiplegia", the Panagoda Correspondence clarifies this to be a reference to "asymmetrical neurological impairments with the left being affected in hemiplegic-like pattern"; and

(d) Mr Lowe had a "high level of function", albeit a significant decline from his premorbid athlete level.

Dr Coyne Consultation

51 Following a consultation with Mr Lowe, the neurosurgeon Dr Terry Coyne prepared a report dated 10 January 2023 (at the request of the Insurers' solicitors). His findings and opinions included:

(a) on examination, the cervical spine range of motion was normal, and Mr Lowe had "subtle weakness of the left upper and lower limbs compared to the right…weakness was slightly more pronounced in the left upper limb than the left lower limb" (p. 4). He recorded Mr Lowe's gait in the office as being "normal" (p. 4);

(b) that the 2016 Injury "resulted in myelopathic symptoms (bilateral distal upper limb sensory impairment)" (p. 5);

(c) after the second surgery, there was "radiological evidence of injury to the spinal cord, with thinning and signal change within the left side of the spinal cord at the C5/C6 level" (p. 5);

(d) in the 2016 Injury, he sustained an acute C5/6 disc protrusion with spinal cord compromise. Whilst his symptoms resolved, "the finding of subtle cervical spinal cord signal change on multiple MRI scans through to August 2017 suggest that his cervical spine and spinal cord sustained a significant injury in September 2016, and although asymptomatic following surgery Mr Lowe's spinal cord may have had less reserve in the event of a further significant injury" (p. 7, question 5).

(e) "As a result of the 2016 incident Mr Lowe sustained an acute C5/6 disc protrusion with clinical and radiological features of cervical spinal cord compromise, for which he underwent surgery. I expect this history indicates a significant condition resulting from the 2016 incident, although there were no ongoing clinical sequelae" (p. 7);

(f) that in the medical literature, "hemiplegia" most often refers to complete paralysis down one side of the body whereas "hemiparesis" is the term for partial weakness. However, there may be some looseness of how strictly the differentiation between hemiplegia and hemiparesis is applied (p. 6, question 2);

(g) that in his view, Mr Lowe would not generally be considered to have hemiplegia, as he has left sided weakness but not total loss of voluntary movement in his left upper and lower limbs. However, Dr Coyne noted that there may not be an appreciation of a

difference between hemiplegia and hemiparesis in the non-medical world and hemiplegia may be a common term for any degree of unilateral weakness. (p. 6, question 3);

(h) that Mr Lowe's condition is likely permanent (p. 7, question 4); and

(i) that both the 2016 Injury and the 2020 Injury have "likely" together resulting in Mr Lowe's current condition, in that it is "likely" that the first incident resulted in a predisposition to a further injury in the event of significant force to the cervical spine. However, Dr Coyne did note that it is "possible" that even if the 2016 Injury had not occurred, sufficient force to the cervical spine (such as that which occurred in 2020) may have resulted in a de novo C5/6 disc protrusion with the same outcome (p. 8, question 8). I note that the use of the word "likely" in this passage appears to mean "more likely than not", in contradistinction to the word "possible" in the last sentence. Indeed, Dr Coyne used the word "probable" in cross-examination in saying that it is probable that the 2020 Injury acted on what was already reasonably significant radiological pathology to result in the disc protrusion now being of a greater extent than it was before that injury occurred (T77.11–18).

52 Dr Coyne confirmed in his oral evidence that he agreed with Dr Mobbs' conclusion expressed in these terms: "His second injury was almost certainly made worse by the neural vulnerability created by the first injury" (T62.40–45). Dr Coyne's agreement with that sentence reinforces the conclusion that Dr Coyne's use of "likely" (p. 8, question 8) should be taken to mean "more likely than not".

Dr Mobbs Consultation

53 Mr Lowe was examined by the consultant neurologist Dr Rowena Mobbs on 23 February 2024 at the request of Mr Lowe's solicitors.

54 Among other things, Dr Mobbs' findings include:

(a) hemiplegia can refer to either brain or spinal cord pathology causing "near or complete paralysis" (p. 5, para 1(a));

(b) functional measures of "incomplete hemiplegia" are important for determining an injury that approximates complete injury (p. 6, para 2(c)).

(c) paraplegia, quadriplegia and triplegia each refer to "near or complete paralysis of" the legs, the arms and legs, and three limbs respectively (p. 6, para 3); monoplegia,

hemiplegia, paraplegia, and quadriplegia are analogous terms that refer to complete or nearly complete paralysis of the involved limbs (p 5, para 1(c));

(d) a functional assessment can have "subtle or partial movement or near paralysis or dysfunction that is of such severity that an incomplete or near paraplegia, quadriplegia, or triplegia may be interpreted" (p. 6, para 4);

(e) that Dr Mobbs' "interpretation" was that Mr Lowe "has a diagnosis of near paralysis and therefore incomplete hemiplegia" (p. 7, para 1(a));

(f) hemiplegia refers to "a severe or complete loss of strength" whereas hemiparesis "refers to a relatively mild loss of strength" (p. 5, para 1(b));

(g) "Brown-Sequard syndrome" describes an incomplete spinal cord injury, affecting fibres in one half or hemisection of the spinal cord. The manifestation can range from mild to severe, and hemiparesis and hemiplegia can each form part of a Brown-Sequard syndrome (p. 6, paras 1(e) and (f));

(h) incomplete hemiplegia is a term referring to near paralysis with injury approximating paralysis in a functional sense; it is incomplete due to the preservation of at least some functioning axonal pathways (nerve fibres) such that a degree of movement still exists, but this movement is insufficient to fulfil remotely normal functioning for that individual (p. 6, para 2(a));

(i) although Mr Lowe symptomatically returned to normal after the first injury, "he may have had ongoing spinal microscopic compromise from this event that meant a vulnerability to more severe injury" (p. 3, para 2);

(j) Mr Lowe's impairment in basic activities of daily living might be deemed a "near complete" injury (p. 3, para 4);

(k) that by the "most strict of medical criteria, Mr Lowe has a diagnosis of hemiparesis" but that on Dr Mobbs' interpretation, Mr Lowe has "a diagnosis of near paralysis and therefore incomplete hemiplegia" (p. 7, para 1(a)); and

(l) Mr Lowe's second injury (being the 2020 Injury) was almost certainly made worse by the neural vulnerability created by the 2016 Injury (p. 3, para 5).

Credibility of Witnesses

Mr Lowe

55 Mr Lowe was an impressive and credible witness who gave clear and careful answers to the questions put to him. He showed a sound understanding of the medical advice which had been given to him from time to time. I accept his evidence as truthful and reliable.

56 Mr Lowe's oral evidence provided considerable detail on his physical capacity, both currently and before the 2020 Injury. Mr Lowe now goes to the gym two or three times a week for sessions of between 30 and 40 minutes. He performs squats with 80 kg weights on a dumbbell across the back of his shoulders, doing five or six squats each time, and does that three times in a session. Before the 2020 Injury, Mr Lowe could squat with 150–160 kg weights. Mr Lowe now does single-arm bench presses, with 30–35 kg on his right and 15–20 kg on his left. He does single-arm lat pull downs, with 50–60 kg on his right side and 25–30 kg on his left side. Before the 2020 Injury, Mr Lowe used to do chin-ups with weights, being his bodyweight of 110kg plus 20–30 kg. Mr Lowe now does tricep extensions, in which he holds a wire handle and extends his arm down while standing up, with 20 kg on his right side and 5 kg on his left. Before the 2020 Injury, he did tricep extensions with 40–50 kg weights. Mr Lowe now does single-leg squats without weights, typically five on his left leg and 10–15 on his right leg, and does that three times in a session. Before the 2020 Injury, Mr Lowe did single-leg squats with a weight of 60 kg. Mr Lowe now rides a bike for 10–20 minutes in a typical gym session, and does not measure his heart rate. Before the 2020 Injury, Mr Lowe would be on the bike for 30 minutes at a heart rate of 180 plus. Mr Lowe now runs once or twice a week, at a distance of up to 3 kms which takes him 20 minutes, being a slow jog. Before the 2020 Injury, Mr Lowe was able to cover 3 kms in 10–12 minutes. Mr Lowe swims but not on a regular basis, and says that he is able to swim several hundred metres.

57 Mr Lowe describes his current symptoms as follows:

(a) numbness in my left forearm;

(b) numbness in my left hand;

(c) tingling sensation in four of my fingers of my left hand;

(d) weakness and stiffness in my left arm;

(e) lack of control in my left arm;

(f) spasms in my left quadricep and left hand, which is made worse in cold weather;

(g) my left hand getting stuck in a "claw" like position;

(h) difficulty holding objects in my left hand;

(i) difficulty writing with my left hand (being my dominant hand);

(j) poor balance;

(k) pain and cramping in my back and neck when sitting;

(l) weakness in my left leg

(m) tendency for my left knee to buckle;

(n) diminished sensory levels in my left hand, which at times has caused me to burn my hand.

58 Mr Lowe says that he struggles with completing everyday activities, for example:

(a) walking the dog;

(b) tying my shoelaces; and

(c) holding cups steady.

Dr Mobbs

59 Dr Mobbs is a consultant cognitive neurologist who is well-qualified to give expert evidence on the meaning of "hemiplegia" and whether that is an appropriate description of Mr Lowe's condition. However, Dr Mobbs' evidence was unsatisfactory in a number of respects, and I place little reliance on her opinions. I formed the impression that Dr Mobbs' concern for Mr Lowe (which is undoubtedly an important quality in a clinician) adversely affected her impartiality as an expert witness. The main shortcomings in her evidence are as follows.

60 First, Dr Mobbs accepted in cross-examination that the opinion expressed in her report that Mr Lowe has a diagnosis of "near paralysis" (p. 7, para 1(a)) was wrong, and agreed that Mr Lowe is nowhere near having any condition of near paralysis: T53.4–24, 54.37–38. That concession was fundamental to the opinion expressed in her report, in that a diagnosis of near paralysis was said in her report to constitute "incomplete hemiplegia", being a term referring to "near paralysis with injury approximating paralysis in a functional sense" (p. 6, para 2(a); p. 7, para 1(a)). Dr Mobbs sought to say in cross-examination that "severe weakness" would be more accurate and that is the term which she intended to use: T53.22–35. The term "severe weakness" does not appear to have been used by Dr Mobbs in her report, and I do not accept that Dr Mobbs intended to use that term but instead used the term "near paralysis" by mistake

(as Dr Mobbs sought to say at T54.17–27). Rather, I think the reference to "severe weakness" was an afterthought, bearing in mind that Dr Mobbs was present in Court when Mr Lowe was giving his evidence as to his physical capacities in doing gym exercises, running and swimming.

61 Second, Dr Mobbs flatly contradicted the opinion expressed in her report that the 2020 Injury was "almost certainly made worse by the neural vulnerability created by" the 2016 Injury (p. 3, para 5), saying that that proposition was incorrect: T49.40–50.22. When taken to that part of her report, Dr Mobbs accepted that the opinion stated in her report accurately reflected her opinion at the time. Although Dr Mobbs was not asked to express an opinion on the question whether the incident in 2020 was the sole and independent cause of Mr Lowe's bodily injury, I regard the opinion stated in her report as a significant matter in relation to that question.

62 Third, Dr Mobbs gave evidence in cross-examination that severe weakness is assessed by reference to the patient's reduction in strength relative to previous capacity, rather than by reference simply to the patient's remaining capacity: T42.35–41, 44.4–42, 57.10–19, 58.6–11. No medical study or literature was cited in support of that approach. Dr Mobbs accepted that her opinion that Mr Lowe suffers from hemiplegia is dependent upon comparing his degree of function as an elite athlete with his position now: T44.33–35. The fact that these propositions were not conveyed in Dr Mobbs' report causes me serious misgivings as to the reliability of Dr Mobbs' opinions, particularly in circumstances where the report contains the mandatory declaration that the expert has made all the enquiries which she believes are desirable and appropriate, and that no matters of significance which she believes are relevant have, to her knowledge, been withheld from the Court (p. 2). Further, the report was said to contain reference to all matters which Dr Mobbs considered significant (p. 8). Moreover, the evidence shows that there are two objective scales by which functional impairment is measured, neither of which involves a comparison between the patient's capacity before and after the spinal cord injury.

63 In the first place, the American Spinal Injury Association Impairment Scale (**AIS**) is a standardised neurological examination used to assess the sensory and motor levels affected by a spinal cord injury (Exhibit C). The scale has five classification levels, ranging from complete loss of neural function in the affected area to completely normal. The scale has grades A to E, with A being where the impairment is complete, and E being where the patient's functions are normal. In relation to Mr Lowe, all of the medical experts (including Dr Mobbs) who utilised

this scale to assess the degree of the loss of neural function assessed him as having an impairment grade D, being where motor function is preserved below the neurologic level and the joints can be moved against gravity. This comprises:

(a) Dr Mobbs, whose report states that "Mr Lowe has a spinal cord injury under the ASIA ISNCSCI categorised as D" (p. 7, para 1(b));

(b) Dr Panagoda, whose letter to Dr Wheeler records Mr Lowe's background as "C5 AIS D spinal cord injury (atypical Brown-Sequard Syndrome) due to a traumatic disc prolapse sustained whilst playing professional rugby league in 2020" (CB393); and

(c) Ms Lucy Maugham, physiotherapist, who recorded Mr Lowe as "31 yr old gent with C5 AIS D due to rugby league injury 2020 in NSW" (CB152).

64 An alternative measure is the American Spinal Injury Association International Standard for Neurological Classification of Spinal Cord Injury (**ISNCSCI**), which provides a scale for detailed clinical assessment that may be used to interpret degrees of motor dysfunction (Dr Mobbs' report, p. 5, para 1(d)). The scale has grades from 0 to 5, with 0 being total paralysis, and 5 being normal active movement, full range of motion against gravity, and full resistance in a functional muscle position expected from an otherwise unimpaired person. Grade 4 is active movement, full range of motion against gravity and moderate resistance in a muscle specific position. All of the medical practitioners who assessed Mr Lowe's function by reference to this scale assessed him in the range of 4 to 5, namely:

(a) Dr Parkinson, who in the 2020 Surgery Operation Report states that "Clinically he was weak in the left arm in thumb abduction 4-+/5, brachioradialis 4+/5, triceps 4+/5, infraspinatus 4+/5, wrist and finger extension 4+/5, finger abduction 4+/5. There was light-touch sensory loss over the first dorsal web space, index finger and thumb and over the middle finger with extension to the extensor forearm. Reflexes were not tested. Right upper limb power was normal" (CB144).

(b) Dr Farey, who in his 2 November 2020 letter states that "Neurological examination revealed strong Grade IV power in the left triceps and left quadriceps muscles on the left side and hyperreflexia in the left lower limb with the plantar responses being flexor" (CB147, 345, 386).

(c) Dr McDonald, who noted on 22 October 2020 that "on assessing the upper limbs there was weakness of left shoulder abduction, external rotation and on supraspinatus testing

(power 4-4.5/5), weakness of left triceps (4/5) and decreased power on pincer grip between the left thumb and fingers" (Exhibit E).

65 Dr Mobbs in her report was a lone voice in respect of finger extension (described by her as level 2: unable to raise against gravity) and finger abduction (described by her as level 3: full range of motion against gravity), but consistent with the 4/5 of the ISNCSCI adopted by other experts for elbow flexion and extension, shoulder abduction, adduction, external rotation, internal rotation, hip flexion and extension, knee flexion and extension, dorsiflexion, plantarflexion, internal rotation and external rotation (p. 5, para 14).

66 None of the objective measurements justified a diagnosis of near paralysis, severe weakness, or hemiplegia.

67 Fourth, there was considerable confusion in Dr Mobbs' evidence as to the meaning of the word "hemiplegia". In her report, reference was made to incomplete hemiplegia as a term referring to near paralysis with injury approximating paralysis in a functional sense. In her oral evidence, Dr Mobbs sought to amend her description of "hemiplegia" such that it would read "incomplete hemiplegia is a term referring to near paralysis or severe weakness with injury approximating paralysis in a functional sense": T56.26-34. However, immediately thereafter, she accepted that Mr Lowe does not have paralysis in a functional sense: T56.38–9. After being confronted with her own answer, she then sought to amend her definition again to read "incomplete hemiplegia is a term referring to near paralysis or severe weakness with injury approximating paralysis or severe weakness in a functional sense": T56.43–57.6. While she resisted the proposition that Mr Lowe did not have severe weakness in a functional sense, she made it clear that her position was dependent on comparing him before and after the injury: T56.42-58.12.

68 Fifth, the conclusions to which Dr Mobbs was driven by her evidence in cross-examination became simply untenable. In answer to the proposition that if Mr Lowe had had the same loss of function in both legs which he experienced in his left leg, then it would not be correct to describe him medically as a paraplegic, Dr Mobbs initially sought to avoid giving a direct answer, but then conceded that it would not be correct to describe that hypothetical condition as paraplegia, and said that Mr Lowe would have a paraparesis of the lower limbs: T45.19–35. Dr Mobbs was then confronted with the proposition that if Mr Lowe had the same diminution in function on his right side as he has on his left side, it would not be fair to describe him as being a quadriplegic, to which Dr Mobbs gave the surprising answer that in those circumstances she would describe Mr Lowe as being quadriplegic: T45.43–46.4. Dr Mobbs disagreed with

the proposition that that would be a ridiculous diagnosis (T46.6–7), but as a matter of the proper use of language, I regard that description as untenable. In saying that, I am not denying that anyone would feel sympathy for Mr Lowe, given the very substantial reduction in his physical capacity compared to his abilities and talents as a professional sportsman, in addition to the sympathy one naturally feels for Mr Lowe in having had a very successful career as a professional sportsman brought to a premature end. I note that the Insurers themselves have expressed sympathy for Mr Lowe's condition. However, the questions which I am faced with involve objective matters of fact and law concerning the restrictive terms in which the Policy is expressed.

Dr Coyne

69 Dr Coyne is a highly experienced neurosurgeon who is exceptionally well qualified to provide expert opinion evidence as to the meaning of "hemiplegia" and whether Mr Lowe suffers from that condition, in addition to the other questions on which his opinion was sought and obtained. I refer to Dr Coyne's evidence below. At this point, I should indicate that Dr Coyne gave evidence in a measured way, giving clear and direct answers to the questions put to him, and making concessions where they were appropriate. The evidence in his cross-examination was in substance consistent with his report. By a very considerable margin, I prefer the evidence of Dr Coyne to that of Dr Mobbs in circumstances where their opinions and reasons conflict.

Is Mr Lowe's condition "hemiplegia" on the proper construction of the Policy?

70 Construction of an insurance policy, being a kind of commercial contract, should be approached according to the principles of businesslike interpretation which are applicable to commercial contracts generally: *CGU Insurance Ltd v Porthouse* [2008] HCA 30; (2008) 235 CLR 103 at [43] (Gummow, Kirby, Heydon, Crennan and Kiefel JJ). Those principles were relevantly set out by French CJ, Nettle and Gordon JJ in *Mount Bruce Mining Pty Ltd v Wright Prospecting Pty Ltd* [2015] HCA 37; (2015) 256 CLR 104 at [46], [47] and [51] to the following effect:

(a) the rights and liabilities of parties under a provision of a contract are determined objectively by reference to its text, context (being the entire text of the contract as well as any contract, document or statutory provision referred to in the text of the contract) and purpose;

(b) in determining the meaning of the terms of a commercial contract, it is necessary to ask what a reasonable businessperson would have understood those terms to mean; that

enquiry will require consideration of the language used by the parties in the contract, the circumstances addressed by the contract and the commercial purpose or objects to be secured by the contract; and

(c) unless a contrary intention is indicated in the contract, a court is entitled to approach the task of giving a commercial contract an interpretation on the assumption that the parties intended to produce a commercial result; a commercial contract should be construed so as to avoid it making commercial nonsense or working commercial inconvenience.

71 Words and phrases used in a contract are usually given their ordinary meaning, unless there is a good reason to depart from that approach, such as where the term is intended to be used as a term of art rather than in its popular sense: *L Schuler AG v Wickman Machine Tool Sales Ltd* [1974] AC 235 at 264 (Lord Simon); *Lasermax Engineering Pty Ltd v QBE Insurance (Australia) Ltd* [2004] NSWSC 483 at [16] and [24] (Einstein J); *Rheem Australia Pty Ltd v Mitsui Sumitomo Insurance Company Ltd* [2023] FCA 1570 at [12].

72 In the present case, both parties led expert evidence as to the technical meaning and usage of the word "hemiplegia". If the meaning of technical or scientific terms is disputed, the meaning may be established by expert evidence: *Quasar Resources Pty Ltd v APG Aus No 3 Pty Ltd* [2023] WASCA 171 at [49]–[54] (Beech and Vaughan JJA), [208] (Lundberg J); JD Heydon, *Heydon on Contract* (2019) [8.390].

73 The term "hemiplegia" is not defined in the Policy, although the word "permanent" is so defined. In my view, the term "hemiplegia" is intended to be used as a term of art in the Policy. I cannot recall ever having heard or seen the word "hemiplegia" before hearing his case, and I regard it as a technical medical term rather than a word which is used in ordinary English. Nor have I ever encountered the word "triplegia" (which is also used in Item 1 of the list of Insured Events) before hearing this case, although its meaning might readily be deduced from the prefix "tri" meaning three, and "plegia" taking its meaning from a comparison with paraplegia and quadriplegia. The words "paraplegia" and "quadriplegia" are often used in everyday English to refer to paralysis of the legs or of all four limbs respectively, although they are also technical medical terms. In my view, reasonable people in the position of the parties would expect the terms "paraplegia", "quadriplegia", "hemiplegia" and "triplegia" in Item 1 to bear their technical medical meaning.

74 That conclusion is reinforced by the contrast with the language used in Items 2, 3 and 4, which use ordinary English language rather than medical terms. Counsel for Mr Lowe places reliance on the use of the word "total" in Items 2, 3 and 4, and draws attention to the absence of that word in Item 1. I do not regard that as significant in itself. The question is whether, or to what extent, the concept of "total loss" is embedded within the technical medical meaning of the conditions referred to in Item 1. The Insurers also rely on the use of "total loss" in Items 2, 3 and 4, in submitting that consistency and cohesion require that the concepts referred to in Item 1 also require total loss of 2, 3 or 4 limbs respectively. However, in my view that again depends on the technical medical meaning of the conditions referred to in Item 1.

75 Before turning to the expert evidence, it is worth noting that the immediate context in which the word "hemiplegia" appears is in association with references to paraplegia, quadriplegia and triplegia, any of which leads to the same monetary benefit. That is an indication that "hemiplegia" is intended to refer to a comparable level of paralysis to that conveyed by "paraplegia", "quadriplegia" and "triplegia" when applied to the limbs in question. Dr Mobbs said that paraplegia, quadriplegia and triplegia refer to near or complete paralysis (of the legs, legs and arms, or three limbs respectively): report, p. 6, question 3. (Dr Coyne did not deal with the meaning of those other terms.) In my view, Dr Mobbs' evidence as to the meaning of those terms provides a strong indication that "hemiplegia" is intended to mean near or complete paralysis of the limbs on one side of the body, with the word "near" understood as meaning "near complete".

76 Dr Coyne gave the following evidence in his report (p. 6) in answer to the question "What is hemiplegia?":

> The exact meaning of hemiplegia varies according to the source, particularly when also considering the term hemiparesis.
>
> The Merriam-Webster dictionary defines hemiplegia as total or partial paralysis of one side of the body. This dictionary defines hemiparesis as partial paralysis of one side of the body.
>
> Dictionary.com describes hemiplegia as total paralysis of one side of the body and hemiparesis as partial or slight paralysis or weakness affecting one side of the body.
>
> The US National Institute of Health (NIH) describes hemiplegia as referring to severe or complete loss of strength on one side of the body, whereas hemiparesis refers to relatively mild loss of strength.
>
> In my medical education hemiplegia was generally considered to be total paralysis while hemiparesis was considered to be partial paralysis (weakness but not complete loss of function) in one side of the body.

> Overall, in the medical literature hemiplegia most often refers to complete paralysis down one side of the body whereas hemiparesis is the term for partial weakness, such as with Mr Lowe. However, there may be some looseness of how strictly differentiation between hemiplegia and hemiparesis is applied. As noted the Merriam-Webster dictionary allows that hemiplegia can mean either total or partial loss of power.

77 In his oral evidence, Dr Coyne acknowledged that there was a looseness of language among medical practitioners, who often use the terms "hemiplegia" and "hemiparesis" interchangeably, particularly among practitioners who do not practise full time in neurology, neurosurgery or spinal injuries: T79.17–34. Dr Coyne acknowledged that Dr Parkinson, a neurosurgeon, had described Mr Lowe's injury as "a spinal cord injury and hemiplegia" in his three-line letter of 27 April 2022 (CB149), and said that if Dr Parkinson wished to call it hemiplegia and if he had his reasons for differentiating between hemiplegia and hemiparesis then that was a matter for him, in circumstances where the classification does not make any difference to the medical management or treatment of Mr Lowe: T82.34–83.5. However, Dr Coyne adhered to the view that, in the medical literature and among most people who practise in the area, hemiplegia is complete or near complete loss of movement down one side of the body: T82.17–19. That evidence involved a minor qualification to the last paragraph of the passage which I have extracted above from Dr Coyne's report, which referred to "complete paralysis" down one side of the body. Dr Coyne clarified that the reference to "complete paralysis" should be expanded to refer to "complete or near complete loss of movement down one side of the body", but said that by "near complete" he meant a situation where the patient cannot move their arm, but they can have "a flicker of a finger": T85.11–22. However, Dr Coyne was not prepared to go as far as Dr Mobbs in including within the concept of "hemiplegia" the concept of "incomplete hemiplegia", which Dr Mobbs said was "a term referring to near paralysis with injury approximating paralysis in a functional sense" (p. 6, para 2(a) of her report). Dr Coyne said that apart from the circumstance where there are flickers of movement, hemiplegia in the medical world is "all or nothing", and that is what is taught at medical school and how papers are written and literature is interpreted: T85.24–45. In terms of the ISNCSCI system of grading from 0 to 5, Dr Coyne would accept that grade 0 (being total paralysis) or grade 1 (being palpable or visible contraction, or what Dr Coyne described as a flicker) would be what most doctors would call hemiplegia, but movement greater than grade 1 is hemiparesis when the terms are used correctly: T88.1–12.

78 As I have indicated above, I accept the evidence of Dr Coyne in preference to the evidence of Dr Mobbs where they conflict. I accept the evidence of Dr Coyne that the term "hemiplegia"

refers to complete or near complete loss of movement down one side of the body, understood in the sense that "near complete" extends only to flickers of movement but no real movement in the limb itself. In terms of the ISNCSCI system of grading, the word "hemiplegia" as used in the Policy corresponds to grade 0 and grade 1, but not any grade above grade 1. In making these findings, I bear in mind the caution to be exercised in the use of dictionaries in construing words as used in contracts: *Lasermax Engineering Pty Ltd v QBE Insurance (Australia) Ltd* [2005] NSWCA 66 at [104]–[107] and the cases cited there.

79 Counsel for Mr Lowe draws attention to the use by three medical practitioners of the term "hemiplegia" in describing Mr Lowe's condition. First, in one of the two versions of his letter of 2 November 2020, Dr Farey, an orthopaedic surgeon, used the term "hemiplegia" (CB147, but not in the version at CB345 and 386). I regard the use of the term by Dr Farey as an instance of technically incorrect use of language in circumstances where there was no occasion to differentiate between hemiplegia and hemiparesis from the point of view of medical treatment or management. Dr Farey's letter did not contain any indication that the term "hemiplegia" was being used in any different sense from the word "hemiparesis", and the fact that Dr Farey referred to Mr Lowe having "strong Grade IV power in the left triceps and left quadriceps muscles on the left side" indicates that Dr Farey was not seeking to convey that Mr Lowe suffered from complete or near complete paralysis on the left side of his body. Accordingly, I do not attach any significance to Dr Farey's use of the term "hemiplegia".

80 Dr Parkinson, a neurosurgeon, used the term "hemiplegia" in his three-line letter of 27 April 2022 (CB149), but did not use the term in his longer letters of 25 November 2021 and 4 March 2022 (Exhibit D). While Dr Parkinson is a neurosurgeon, I do not attach any significance to his reference in the last in time of those three letters to "hemiplegia" in circumstances where the correspondence does not convey any reason for the use of the term as distinct from "hemiparesis", and does not give any indication of what Dr Parkinson meant by the term "hemiplegia". As with Dr Farey, this appears to be an instance of technical misuse of language in circumstances where the classification of the injury made no difference to the medical management or treatment of Mr Lowe.

81 Dr Panagoda said in the Panagoda Progress Notes that Mr Lowe "presents as (L) Hemiplegia" (CB156), but that was clarified in the Panagoda Correspondence as Mr Lowe's incomplete cervical spinal cord injury presenting "as asymmetrical neurological impairments with the left being affected in hemiplegic-like pattern" (CB395). In my view, Dr Panagoda was seeking to

convey that Mr Lowe's spinal cord injury adversely affected the left side of his body only, and in that respect was akin to the kind of pattern one observes with hemiplegia. I do not read Dr Panagoda as having proffered a diagnosis of hemiplegia itself. In any event, as I have indicated above, Dr Panagoda graded Mr Lowe's injury as level D according to the AIS, which is inconsistent with a diagnosis of hemiplegia in the technical medical sense.

82 I reject the submission made by counsel for Mr Lowe that the mere fact that medical practitioners had used the term "hemiplegia" in relation to Mr Lowe was evidence of accepted technical usage of the term, and also the submission that it is sufficient for his case to show that medical practitioners have used the term "hemiplegia" (whether correctly or not) in referring to Mr Lowe's condition. Rather, consistently with Dr Coyne's evidence, I regard the usage by these practitioners as showing a technical misuse of language in circumstances where the classification of Mr Lowe's condition as either hemiplegia or hemiparesis was immaterial to the medical treatment of Mr Lowe, as reflected in the fact that the usage by those three doctors is not accompanied by any indication that they were seeking to differentiate hemiplegia from hemiparesis. However, what may have been for treating practitioners a relatively trivial and needlessly pedantic question about terminology is a matter of fundamental importance in the resolution of the present dispute, as to which I regard the correct technical meaning of "hemiplegia" as explained by Dr Coyne as being of paramount importance.

83 It is clear on the evidence that Mr Lowe does not suffer from complete or near complete loss of movement down one side of the body, and therefore does not suffer from hemiplegia in the proper medical sense of the word. Even if I had adopted the view expressed by Dr Mobbs in her report that hemiplegia includes "incomplete hemiplegia", meaning "near paralysis with injury approximating paralysis in a functional sense", I would not have found that Mr Lowe's condition satisfies that concept. Further, even on the most expansive of Dr Mobbs' attempts to explain the term "hemiplegia", namely "severe weakness", I do not think that Mr Lowe's condition satisfies that definition. It is certainly true that Mr Lowe's strength and physical capacity have been substantially reduced by the 2020 Injury, but I do not regard Mr Lowe's present capacity as one of "severe weakness". As the medical reports in the evidence demonstrate, Mr Lowe's strength and capacity are ranked at the fourth or fifth of five levels of ascending levels of functionality. Accordingly, Mr Lowe does not qualify for any of the benefits under the Policy.

Was Mr Lowe's condition caused solely and independently of any other cause?

84 In light of the reasons and conclusion expressed above to the effect that Mr Lowe does not suffer from hemiplegia as that term is used in the Policy, it is not necessary to address this question. However, as there is a substantial body of evidence directed to the issue, and the matter has been fully argued, it seems to me desirable that I express my views on the issue. I will deal first with the contemporaneous documentary evidence, and then deal with the expert evidence given at the hearing, before turning to the relevant legal principles and their application.

85 Following the 2016 Injury, the contemporaneous medical reports contained a number of references to "signal change in the cord" (which Dr Coyne said indicated a structural abnormality within the spinal cord: T86.28–30), oedema (i.e. swelling: Dr Coyne at T86.32–33) and myelomalacia (i.e. scarring: Dr Coyne at T86.34) on Mr Lowe's spinal cord noted in MRI scans performed on his cervical spine:

(a) the first MRI report taken two days after the 2016 Injury by Dr Geoffrey Haussman noted "significant deformity of the cord" (CB116);

(b) the MRI report of Dr Alan Boles dated 9 January 2017 noted that "the pre operative study does demonstrate minor cord oedema at the C5/6 level however this appears to have largely resolved" (CB437). In his oral evidence, Dr Coyne recalled after this scan "a little bit of residual signal change within the spinal cord on subsequent MRI scans" (T67.1–2);

(c) the MRI report of Dr Tyson Reeve dated 1 April 2017 initially stated "no cord oedema", but an amendment was added on 3 April 2017 noting that "there is very subtle hyperintense signal in the left lateral aspect of the cord which could reflect mild cord oedema or myelomalacia…given the history of new symptoms, this does raise the possibility of recent injury to the cord" (CB125–6). When asked about this scan in cross-examination, Dr Coyne opined that there was some oedema in that scan, and "any signal change [within the spinal cord] is probably of some significance because it means a spinal cord has had a physical injury" (T70.8–71.7);

(d) the MRI report of Dr Charlotte Slaney dated 4 May 2017 noted it was possible "that there is a subtle area of increased T2 signal within the left lateral aspect of the cord which may indicate mild oedema or myelomalacia." Dr Slaney also noted that "it is

possible that there is a small amount of oedema in the left lateral cord at the site of indentation by the focal disc bulge"(CB132–3);

(e) in Dr Guazzo's letter to Dr Ball dated 5 May 2017, Dr Guazzo noted his review of Mr Lowe's MRIs that "[t]he small area of signal change in the cord was evident on the previous MRIs and relates to the initial disc protrusion" (CB131). In cross-examination, Dr Coyne opined that any change was "pretty marginal" and that "there wasn't significant change" (T73.13–16);

(f) the MRI report of Dr Alan Boles dated 8 June 2017 noted that "the disc protrusion effaces the CSF space anterior to the cord with some distortion of the left side of the cervical cord…The increased signal intensity within the left side of the cord at this level extending over the 14mm longitudinal length is similar to previous imaging" (CB135);

(g) the MRI report of Dr Kurundeniya Prematunga dated 31 August 2017 noted that "There is anterior indentation to the thecal sac and the spinal cord. There is oedema of the cord extending from the lower border of C4 to upper border of C6. The oedema is best demonstrated on sagittal images … There appears to be minimal progression of the cord oedema craniocaudally as demonstrated on sagittal images" (CB137);

(h) the MRI report of Dr Dimmick dated 19 July 2020 recorded that "[h]yperintensity within the left hemi cord extending from the level of the mid C5 vertebral body to the middle C6 vertebral body (1.8 cm in length) appears to be a combination of oedema and myelomalacia" (CB140–1). In his oral evidence, Dr Coyne opined that this scan showed "that there has been sort of an extension or progression of the residual disc protrusion that was left behind after the 2016 surgery" (T77.1–9);

(i) Dr Farey's letter dated 2 November 2020 recorded, from a review of MRI scan on Mr Lowe's phone, "the presence of a large central and left sided disc protrusion at the C5/6 level with marked cord compression and myelomalacia" (CB147, 345, 386);

(j) the MRI report of Dr Gaurav Khera dated 3 November 2021 noted "Reduced volume of left hemicord with bright signal area suggesting chronic myelomalacia at C5/6 level. This is likely sequala to old injury" (CB390); and

(k) the letter from Dr Parkinson to Dr McDonald dated 25 November 2021 noted that repeat MRI imaging showed "residual myelomalacia consistent with a previous cord injury for which the surgery was required" (Exhibit D).

86 The 2016 Surgery involved, among other aspects, the removal of free disc fragments arising from the 2016 Injury (CB120, 122). For the 2020 Surgery, Dr Parkinson's Operative Findings noted a "[f]loating bone fragment due to previous foraminotomy also causing some foraminal compression" (CB144). This is direct evidence of fragments from the 2016 Injury contributing to the compression of Mr Lowe's spinal cord in the 2020 Injury. Dr Coyne said that Mr Lowe was at a higher risk following the 2016 Surgery because of the "floating" fragments of disc that could not be recovered in the 2016 Surgery, although that increased risk could not be quantified (T67.41–68.6). After the 2016 Injury and after the 2016 Surgery, MRI scans revealed that Mr Lowe continued to suffer a persistent, albeit reduced size, left posterior paracentral disc protrusion (CB437, 125–6, 132–3). Dr Guazzo emphasised in correspondence in 2017 that Mr Lowe's risk of further injury had increased following the 2016 Injury, stating on 6 April 2017 that "[t]here must be some increased risk in view of the disc protrusion" (CB127) and on 5 October 2017 that Mr Lowe "must be at slightly increased risk of cord injury if he sustains a serious injury to his neck" (CB136).

87 The contemporaneous documents also show that Mr Lowe was asymptomatic after the 2016 Surgery, in particular Dr Guazzo's letters to Dr Ball of 3 November 2016 (CB123), 12 January 2017 (CB124), 6 April 2017 (CB127), 12 June 2017 (CB134) and 4 December 2017 (CB139). Those findings are consistent with the background that Mr Lowe had continued to play rugby league in the NRL competition during the 2017, 2018 and 2019 seasons, and up to Round 10 in the 2020 competition, and had also suffered the 2017 Injury. Mr Lowe himself said in his affidavit that he had no ongoing symptoms during that period associated with the 2016 Injury (paras 37, 42, 43 and 45–47).

88 In his expert report, Dr Coyne addressed the question: "Insofar as the Claimant suffered a medical or physical condition following the 2016 incident, was it aggravated by the 2020 injury, or combined with the 2020 injury so as to result in the Claimant's current medical condition?", and provided the following evidence (p. 8):

> It is likely that both the 2016 and 2020 incidents have contributed to Mr Lowe's current condition. The 2016 incident likely left the C5/6 disc with a predisposition to further injury, including disc protrusion, in the event of a further significant force to the cervical spine, noting that imaging following Mr Lowe's 2016 cervical spine surgery demonstrated some degree of residual central/left disc protrusion. The subtle signal change within the cervical spinal cord following the 2016 incident indicates that Mr Lowe's spinal cord possibly had less reserve to deal with a second insult.
>
> It is likely that the first incident resulted in a predisposition to a further injury in the event of significant force to the cervical spine. As such both incidents have likely

> together resulted in Mr Lowe's current condition. However is it possible that even in the absence of the first incident sufficient force to the cervical spine as in the second incident may have resulted in a de novo C5/6 disc protrusion with the same outcome.

As I have indicated above, in the context of Dr Coyne's evidence as a whole, I read the word "likely" in that passage as meaning "more likely than not", in contradistinction to the use of the words "possibly" and "possible" in the last sentence of each paragraph in that passage.

89 In his cross-examination, Dr Coyne readily conceded on numerous occasions that Mr Lowe was asymptomatic after the 2016 Surgery. Dr Coyne was taken to Dr Guazzo's letter of 4 December 2017 referring to Mr Lowe being "completely asymptomatic" following the 2016 Injury involving an orbital fracture and significant extension of his neck, and accepted that that was an important matter in indicating that Mr Lowe's neck was capable of sustaining some significant force without any further injury (T74.41–43). However, Dr Coyne did not accept that that demonstrated that Mr Lowe's spine was capable of withstanding the kind of force that can fracture the orbital socket, as distinct from showing that Mr Lowe "got lucky that time" and he did not get lucky a few years later (T74.45–75.9). Dr Coyne accepted that the increased risk resulting from the 2016 Injury of a further disc injury and further neurological symptoms in the future could not be measured and expressed as a figure (T75.35–44; and see T74.26–33). Dr Coyne also accepted that the 2020 Injury was a new injury with new neurological symptoms, but said that the MRI scans showed that it was an extension or progression of the residual disc protrusion that was left behind after the 2016 Surgery, and the 2016 Injury provided the platform on which the 2020 Injury occurred: T76.13–77.18. Dr Coyne was asked specifically about the opinion in his report that the subtle signal change within the cervical spinal cord following the 2016 Injury indicates that Mr Lowe's spinal cord possibly had "less reserve" to deal with a second insult, and agreed that what he was saying is that there was a susceptibility to a greater degree of injury rather than any root cause of injury (T78.42–44).

90 As I have indicated above, Dr Mobbs was not asked specifically to address this question, but expressed the following opinions in her report which are relevant to it:

(a) although symptomatically returned to normal after the 2016 Surgery, Mr Lowe may have had ongoing spinal microscopic compromise from the 2016 Injury that meant a vulnerability to more severe injury (p. 3, para 2); and

(b) the 2020 Injury was almost certainly made worse by the neural vulnerability created by the 2016 Injury (p. 3, para 5).

As I have indicated above, Dr Coyne expressly agreed in his oral evidence with the latter proposition.

91 In her cross-examination, Dr Mobbs accepted that the signal changes at the C5/6 level which existed prior to the 2020 Injury indicated spinal cord damage, insult or compromise, although she described that as "mild" (T54.45–55.9). Dr Mobbs accepted that ongoing traces of oedema and myelomalacia indicated a process of damage to the spinal cord but said that it would not necessarily indicate an ongoing active process and said that if it was a pathological process then it was "minor" (T55.17–23).

92 As I have indicated above, I accept the evidence of Dr Coyne, and in cases of inconsistency I prefer his evidence to that of Dr Mobbs.

93 Turning to the question of legal principle as to the meaning of the expression "solely and independently of any other cause" used in the definition of "Bodily Injury" in the Policy, the relevant authorities on similar wording were considered by the New South Wales Court of Appeal in *Preston v AIA Australia Ltd* [2014] NSWCA 165. In that case, the policy wording referred to a physical injury "which results solely and directly and independently of a pre-existing condition or any other cause in total disablement". That language is arguably more difficult for the insured to satisfy than the wording in the Policy, because of the reference to "pre-existing condition" in addition to "any other cause". However, the authorities reviewed by the Court of Appeal involved substantially the same wording as is used in the Policy in the present case, in referring to the injury being caused solely and independently of all other causes.

94 In *Preston*, Sackville AJA (with whom Meagher and Gleeson JJA agreed), drew a distinction between two situations (at [80]):

> The first is where a dormant or inactive condition creates a propensity in the insured to suffer disabling consequences from what otherwise might be a relatively minor injury. The second is where a significant medical or physical condition is aggravated by the injury or combines with the injury so as to result in disability.

Counsel for both parties in the present case accepted that the approach taken in *Preston* at [80] is applicable to the Policy here.

95 In the first situation, the accidental injury will ordinarily be regarded as the sole, direct and independent cause of the disability. That is illustrated by three cases. In *Fidelity and Casualty Company of New York v Mitchell* [1917] AC 592, the insured severely sprained his wrist and in the ordinary course the sprain would have healed in about six months. However, about ten

years before the accident, the insured had experienced a tubercular infection in one lung resulting in a lesion which had completely healed and would have remained harmless but for the accident. The presence of tuberculosis in some form within the insured's system prevented the sprain from healing and resulted in total disablement. In *Silverstein v Metropolitan Life Ins Co* (1930) 171 NE 914, the insured suffered abdominal injuries while lifting a milk can and during surgery on the insured's abdomen, the surgeon found a perforation through which the contents of the insured's stomach escaped, leading to peritonitis and death. A duodenal ulcer about the size of a pea was located at the point of the perforation. But for the accident, the ulcer would have had no effect since it was dormant and not progressive. Even so, the ulcer weakened the wall so that the impact of the blow on the abdomen was followed by perforation at the point of least resistance. In *Lipertis v Australian Casualty Company Pty Ltd* [1983] 2 VR 280, the insured suffered a soft tissue injury to his thoracic spine at work, and subsequently developed a "decompensation reaction" which produced a disabling psychiatric condition. The psychiatric condition was causally related to the trauma of the accident. In the reasoning of Kaye J (at 286), although the insured had a particular type of personality which was susceptible to a decompensation reaction, it was the accident alone which caused the insured to react to his physical injuries in a manner which disabled him from pursuing his normal lifestyle and means of livelihood.

96 In the second situation, the court is likely to conclude that the accidental injury is one of two concurrent causes and is therefore not the sole, direct and independent cause of the disability. That is illustrated by two cases. In *Jason v Batten (1930) Limited* [1969] 1 Lloyd's Rep 281, the insured suffered minor injuries in a motor vehicle accident, and six days later suffered a coronary thrombosis. It was held that there were two concurrent causes of the disablement, one being the insured's pre-existing arterial disease, which would have produced a coronary thrombosis within three years even without the accident. The second cause was the formation of a blood clot as a result of the accident. The arterial disease and the clotting were regarded as simultaneously present together, with each being a necessary condition of the thrombosis. In *Preston* itself, the insured sustained severe injuries to both ankles requiring surgery, and although he was able to resume full time work those injuries to both ankles had continuing and observable physical consequences. When he injured his left ankle in 2009 his pre-existing condition materially contributed to his disability, in that the 2009 injury aggravated the physical consequences of that accident in both the left and right ankles. While the pre-existing condition from 1996 was unlikely to have resulted in permanent disablement if the 2009 injury had not

occurred, there was no evidence that the 2009 injury, independently of the aggravation of the pre-existing condition, would have rendered the insured totally disabled. Accordingly, there were two concurrent causes of the insured's disability, namely the aggravation of his pre-existing condition and the new injuries sustained in 2009.

97 At [97], Sackville AJA said the following:

> If it is necessary to distinguish cases such as *Mitchell* and *Lipertis*, the distinction lies in the fact that the Insured in the present case had a pre-existing physical condition that was susceptible to aggravation, and the aggravation contributed to his total disablement. This is not a case of an inherent propensity, whether by reason of personality or a benign and symptomless minor condition, to the adverse consequences of an accident unrelated to the aggravation of a pre-existing physical condition.

98 The 2020 Injury was undoubtedly made worse by the 2016 Injury. Both the 2016 Injury and the 2020 Injury were to the same part of Mr Lowe's spine, located at the C5/6 level. The effect of Dr Coyne's evidence is that it is more likely than not that both the 2016 and 2020 Injuries contributed to Mr Lowe's current condition. The point is starkly expressed by Dr Mobbs in her report, to the effect that the 2020 Injury was almost certainly made worse by the neural vulnerability created by the 2016 Injury, a proposition with which Dr Coyne agreed.

99 Nonetheless, the authorities establish that the language used in the Policy does not preclude a claim by the insured simply because he had a pre-existing condition that can be said to have contributed in some way to his injury. As Cardozo CJ observed in *Silverstein*, the infinite interplay of causes makes it impossible to segregate any single cause as operative to the exclusion of all others. On the approach in *Preston*, the real question is whether the 2016 Injury left Mr Lowe with a "dormant or inactive condition" or a "significant medical or physical condition".

100 The better view is that the 2016 Injury left Mr Lowe with a dormant or inactive condition, rather than a significant medical or physical condition. The evidence establishes not only that Mr Lowe was asymptomatic between the 2016 Injury and the 2020 Injury, but also that he played rugby league at the highest level throughout that period. Accordingly, Mr Lowe's condition was analogous to the tuberculosis in *Mitchell* and the duodenal ulcer in *Silverstein*. The circumstances in *Jason* and *Preston*, by contrast, are distinguishable. Irrespective of the accidents said to give rise to liability, each insured was already suffering significant physical consequences (in the case of *Preston*) or would have imminently suffered such consequences (in the case of *Jason*). But for the 2020 Injury, the 2016 Injury would have had no physical effect on Mr Lowe.

101 I acknowledge that there is one respect in which the present case is closer to *Preston* than *Mitchell* or *Silverstein*. In *Preston* and the present case, the insured's predisposition to injury and the injury itself arose from two similar incidents — during the insured's work, force was applied to the injured part of the body. In *Mitchell* and *Silverstein*, by contrast, the cause of the insured's predisposition was entirely unrelated to the ultimate injury. The injury was caused by the application of force to the injured part of the body, but the predisposition arose from an infection (in the case of *Mitchell*) or stomach ulcer (in the case of *Silverstein*).

102 However, in my view, the physical correspondence between the causes of the predisposition and injury in the present case does not distinguish *Mitchell* and *Silverstein*. In the present case, the ultimate question is whether the 2020 Injury was caused by an Accident "solely and independently of any other cause". The 2016 Injury is thus relevant only for its effect on Mr Lowe. As has been explained, the effect on Mr Lowe was analogous to the effect of the infection in *Mitchell* and the stomach ulcer in *Silverstein*.

103 In sum, under the dichotomy in *Preston*, this is a case in which a dormant or inactive condition created a propensity in the insured to suffer disabling consequences. Mr Lowe's injury was made worse by that propensity, but it was still caused by an Accident "solely and independently of any other cause".

Conclusion

104 In light of the conclusion I have reached on the hemiplegia issue, Mr Lowe's claim for a declaration and order for indemnity must be dismissed. Counsel for Mr Lowe expressed a preference for dealing with the question of costs after delivery of these reasons. Although counsel for the Insurers did not accept that that was the appropriate course, I am prepared to accede to the preference of counsel for Mr Lowe. Accordingly, I have made directions for the filing and service of written submissions and affidavits on the question on costs, which I anticipate I will decide on the papers.

I certify that the preceding one hundred and four (104) numbered paragraphs are a true copy of the Reasons for Judgment of the Honourable Justice Jackman.

Associate:

Dated: 2 August 2024